Transcript of SAMHSA Webinar

June 15, 2011

Overview of Permanent Supportive Housing and Recovery Support

Introduction (Justine Hanson):

Good afternoon and welcome to today's SAMHSA Webinar "Overview of Permanent Supportive Housing and Recovery Support." My name is Justine Hanson and I am the Deputy Project Direct for SAMHSA's Homelessness Resource Center. It is my pleasure to serve as your moderator for today's presentation. Today's webinar will provide an overview of the core elements of the PSH module and a general orientation to SAMHSA PSH EBP toolkit. It will focus on lessons learned from the process of implementing PSH in Detroit, Michigan by Southwest Counseling Solutions. This is the first of a series of four webcasts on SAMHSA's PSH toolkit. We are honored to have presenters Fran Randolph, Ann Denton and Joseph Tardella with us today.

I would like to acknowledge our audience members so you know who your colleagues are on this call. We have consumers, providers, policy makers, family members and administrators on with us. There are over a 1,000 people registered for the presentation, a volume that speaks to the need and readiness of information about permanent housing and recovery support.

After some logistical announcements, the presentation part of the webinar will last approximately an hour and then we will have time for a question and answer session. I will introduce each presenter before his/her presentation. First some logistical information: all presenters will remain on mute for the duration of the call. Materials from today's presentation will remain on SAMHSA HRC within seven days, that's http://www.homeless.samhsa.gov. We welcome questions and will have time for a Q&A session after the presentation. You may submit your questions at any time throughout the

presentation using the Q&A dialogue box on the upper left hand of your screen. The presenters' will respond to questions at the end of the presentation.

The goals of today's presentation are to become familiar with the core elements of SAMHSA PSH EBP Kit, understand how to best align your program with the core elements of the PSH toolkit, and be able to identify the issues that need to be addressed, the questions to be asked, and the stakeholder that you need to engage during the planning and development of a PSH program.

Now it is my pleasure to introduce Dr. Fran Randolph, the Director of the Division of Services and System Improvement and the Center for Mental Health Services at SAMHSA. Dr. Randolph oversees the Community Support Programs Branch, the Children, Adolescent and Families Branch and the Homeless Programs Branch. Her specific areas of responsibility include directing SAMHSA's Primary snd Behavioral Health Integration Program, The Project for Assistance In Transition from Homelessness Program, and the Services in Supportive Housing Program. Prior to becoming the division director, Dr. Randolph was the Chief of the Homeless Programs Branch where she was responsible for managing a multi-research demonstration on supportive housing. Fran, thank you so much for being with us today.

Fran Randolph:

Thank you Justine for that very nice introduction. On behalf of my administrator, Pam Hyde and my center director, Kathryn Powers, I welcome all of you to this SAMHSA sponsored webinar on PSH. We are very pleased to sponsor this four part series on supportive housing. We know that supportive housing works. The research has shown that this approach is effective in reducing homelessness. It is also effective in helping people with mental illness and with co-occurring disorders achieves recovery. We at SAMHSA are committed to the supportive housing model. In addition to funding the SSH program, SAMHSA also developed the toolkit on supportive housing. Furthermore, supportive housing is at the very core of SAMHSA's recovery support strategic initiative, which defines SAMHSA's role in helping to end chronic homelessness. We are pleased that so many of you have signed up for this webinar. The overwhelming response

demonstrates your interest and desire to learn how to create PSH options for our target homeless population. And we are very, very fortunate to have some of the most knowledgeable and experienced presenters of supportive housing on this webinar today. If you do not already have a copy of the supportive housing toolkit, please visit http://www.SAMHSA.gov where you can order the free CDs or download PDF files of the toolkit or you can go to the Homelessness Resource Center web address that Justine just described or announced over the phone. Again, thank you for your interest in this webinar and I also want to thank the staff at the Center for Social Innovation for all of your hard work in developing this webinar. Back to you Justine:

Justine Hanson:

Thank you Fran for that introduction; and now it is my pleasure to introduce Ann Denton who will provide some background on the award winning PSH toolkit. Ann Denton serves as Director for SAMHSA's SSH Technical Assistance Center. She has more than 30 years of experience with public mental health systems, effective partnership at the system level and transition from institutions to community living. Ms. Denton is an expert on PSH including delivery and financing of services and support. Her areas of expertise include effective systems and interventions for persons with mental illness, substance abuse and co-occurring disorders. Ms. Denton has played a leadership role in the development of SAMHSA's PSH toolkit. Ann, it is a pleasure to have you with us today.

Ann Denton:

Thank you Justine and I am really glad to be here. Like Fran, I am gratified by the level of interest in the PSH toolkit and wanted to start by offering some information about how that was developed and what it's based on, as Fran said and as the slide says you can attain a free copy of the PSH toolkit from the website that's on the slide. I just want to tell you what you'll get when you get in there. The kit contains about 7 booklets and 4 or 5 of them are particularly crucial in the implementation of PSH. First of all, there is a booklet titled "The Evidence" which is a compilation of all the years, decades of experience that providers and others have had in providing PSH, and the effects of the housing. As Fran

mentioned, we have good solid research evidence that PSH works, it works in terms of providing people a life that is integrated into the community, and it works because it facilitates real, measurable recovery. So the booklet entitled "The Evidence" is your key to all of that literature.

Another booklet in there is called "Building Your Program" and it is particularly of interest to those of us who are starting from scratch perhaps, or who wonder how does one find housing resources. There's a lot about financing in here, a lot about community allocations about funding for housing, some tips and tools about evaluating a housing market. So for communities or for providers who are interested in starting at that level, the building your program part of the PSH toolkit is of particular interest, and also I would mention that the next webinar in this series which is to be held on June 21st, is all about financing and housing markets and the like, so people who are interested in that I would recommend that you take a look at that.

Finally, or not finally, "Training Front Line Staff" is another one of the key booklets in the toolkit. "Training Front Line Staff" really talks about the core elements and a lot about what we are going to talk about today is drawn from "Training Front Line Staff." It talks about the theory, talks about what it takes to provide PSH, talks about how people choose, get, and keep regular integrated housing, talks about providing reality based recovery support services for individuals and families, talks about providing supports that are focused on helping people maintain housing. So there is a lot in "Training Front Line Staff."

I also want to draw your attention to the booklet called "Evaluating Your Program." In "Evaluating Your Program" you will find a real examination of the dimensions of PSH that underlie fidelity to the model, and in "Evaluating Your Program" you will find a fidelity scale. The purpose of a fidelity scale is to operationalize, if you will, the core elements in a way that you can measure for yourself whether or not you are actually doing the things that we believe underlie successful PSH programs. And back to the webinar series, the 3rd and 4th webinars in this four part webinar series will all be focused

on fidelity, various dimensions of fidelity so I encourage you to watch your email for an announcement of dates and times for those two webinars on fidelity.

I also want to draw your attention finally to a book called "Tools for Tenants." It's a small book but it is filled with things that prospective tenants can work with, so its planning tools for people who may be looking at housing for the first time in their lives or looking at living in their own housing after many years not living on their own, so it's a good, short tool that people can use with prospective tenants.

I also, before we leave this slide wanted to give you a quick understanding of how the toolkit was developed. First of all the compilation of evidence that PSH is successful became overwhelming to the point where SAMHSA really wanted to make it accessible to the community and to disseminate the huge body of research evidence around that success. Part of what happened was a consensus panel was developed pulling from consumers, family member, thought leaders, researchers and practitioners in the field that worked with SAMHSA to develop the content and then finally the product went for SAMHSA approval.

So let's take a look at the core elements of PSH. This first slide underlies what we think of as a fundamental basic idea that underlies the entire approach of PSH, that is, just because someone has a diagnosable mental illness or a co-occurring disorder, their need for housing is fundamentally the same as everyone else's.

Taking a look at what is PSH; this definition on the slide has all of the components of what PSH is; that PSH is decent, safe and affordable, and we'll talk about that in a minute, community based, providing residents with the rights of tenancy. And as I'll discuss in a minute, the rights of tenancy is a very powerful factor I believe driving the success of PSH; and PSH will not facilitate recovery unless you have the ability to provide voluntary flexible supports and services. I want to make it even simpler, PSH is really about two things: it's about housing and it's about supports. On the housing side, the housing needs to be affordable, it needs to be safe, it needs to be available, it needs to be chosen by the resident, it needs to be community integrated, so people need to be able to experience a full life in the community. On the support side, the supports need to be

real and meaningful, focused on housing retention, voluntary and flexible, ongoing, and we do best if we provide people with access to services to all sorts of community benefits, so it's just about what a particular housing program can provide, but linking people to all of the services to which they are entitled.

The supportive housing philosophy is really that people with serious mental illnesses and other disabilities have the same rights and opportunities as all citizens to choose, obtain and live in regular community housing. People have the right to receive, refuse and direct their own support services.

One of the things that I don't want to leave this slide without mentioning is the Olmstead Supreme Court decision. The Olmstead Supreme Court decision really talked about having people live in the most integrated setting possible, and one of the findings in that Supreme Court decision was that the clinically unwarranted segregation of persons with disabilities is in of itself a violation of the ADA (Americans with Disabilities Act). So PSH really helps us achieve the community goals of the Olmstead Supreme Court Decision.

Let's take a look at the core elements of PSH. First of all we are very interested in access to housing. How do people obtain access to the housing itself? Are there readiness requirements in your program that people need to be able to cook or take their own medications before they can get access to housing? Or is it more of a housing first approach? I would emphasize that you can do PSH either way, but how people access is one of the core elements.

The second core element is permanent. Do people have right to tenancy? The third is safe, decent, and affordable, the fourth is integrated, the fifth is separation of housing and services, the next one is choice and the final one is services, and we are going to talk about each of those.

Housing First is one way to provide PSH. In Housing First there are few or no access barriers, in other words there is no readiness screen, and services are very flexible, wraparound, ongoing, continuous and supportive. The core element to be noted here is

the access requirements; to what extent do you expect people to have been made ready, or make themselves ready to be in housing. Housing First is at one extreme in the continuum, and it says there are no access requirements, we will meet you where you are and help you stay in housing. On the other end there may be community constraints or other issues that cause a program or a provider to say it would really be better if all of the tenants in this building had a competency in a certain area, so they may have an access requirement. Again you can do it either way.

The rights of tenancy is a very powerful factor. The rights of tenancy really help distinguish between what's housing and what's a residential treatment program. Many systems still have residential treatment programs where you happen to be in a housing setting or you are certainly living under a roof, but the goal of the program is some kind of therapeutic gain, or a skills gain, and its time limited; it's a residential program. Housing is housing, and the key determinant of that is: does the person have fundamental rights of tenancy? When we talk about residents having full legal rights and a tenant-landlord relationship, we are really talking about legal rights as defined under local landlord-tenant, nothing added, nothing subtracted. Tenants are responsible to abide by the normal standards of behavior conduct outlined in a lease; and just a quick review of those: Tenants are required to pay the rent, tenants are required to not damaged the property, and tenants are required to live in such a way that their neighbors may continue to enjoy their rights of tenancy, that's it. Rights of tenancy are distinct from program rules, and rights of tenancy, the length of stay is determined not by a program but by the agreement between the landlord and the tenant.

Another component is safe, decent and affordable, and when the group of the consensus panel worked on these dimensions and these elements there was a lot of discussion back and forth, we really want people to live in high quality settings. But where the committee ended up was leading the Department of Housing and Urban Development's industry standard around what it safe and decent. What we are talking about here is these are a HUD standard of housing quality standards. So the way you can do this is public housing authorities do H2S, housing quality standards and inspections, on all of their housing choice voucher units, the public housing units, etc. that they are responsible for, and they

can be sometimes persuaded to help you, or you can take training from the public housing authority in how to assess a unit according to these standards. It is a good way to involve public housing authorities actually in the processing's that you are trying to do under PSH. The bottom line takeaway for decent and safe is would you want your mom living there?

Housing affordability is a little trickier. I would ask anybody on this call who has ever bought a house you know that you had to meet an affordability standard in order to qualify for your mortgage. The HUD affordability guideline for rental housing is essentially the same, that a tenant should pay no more than 30% of their adjusted income for housing expenses. Sounds simple, but the reality is that people on SSI are often paying 60%, 80%, 100% of their income towards housing, and sometimes even that housing is substandard.

Ok, let's talk about integration for a minute. Again, I would refer you back to the Olmstead Supreme Court decision and their finding that in order to be in compliance with the ADA we really need to look at people having the opportunity to participate fully in the life of their community. So what this means when you roll it into PSH. Is that housing is located in regular residential areas, housing is scattered site, or it might be single site but if you have mixed population sin the building or mixed populations in the neighborhood, you are still achieving the community integration mandate. We want to avoid these large homogenous congregate sites that become mini institutions.

Another indicator on integration is do tenants participate in community activities and receive community services for which they are eligible, and are we really encouraging the development the use of natural supports: family and friends, church, and community activities.

I want to talk for a minute, I'll come back to choice, I want to talk for a minute about the scattered site versus single site, or mixed population approaches, and just say very clearly that PSH is successfully provided in either scattered site or single site, or a combination of both. It is truly more about a serious commitment to community integration as it is about the physical structure of where people live.

But just to be clear about what we are doing with PSH toolkit, scattered site is defined as you see on this slide, its individual units dispersed throughout an area: apartments, condos, single family houses owned or lease and conforming with local zoning. Single site, mixed population, large building or a complex within multiple units, ideally serving more than one type of tenant. The industry standard for affordable housing at this point is mixed income, mixed use. That's not something that's unique to PSH, so again this model leans into what the industry standard is for affordable housing in general. So mixed income, mixed use is another way to say serves more than one type of tenant. You might have a large tax credit property with a set aside for a specific target group. Another creative way to achieve this is through master leasing, and again the very next webinar in this series, June 21st will talk more about financing and a little bit more about how to do these, the details of these.

Let's go back to choice for a minute. I really want to talk about what do we mean by choice? The way the PSH toolkit is structured really are talking about prospective tenants choosing among different types of housing, choosing among different types of neighborhoods, choosing their actual unit, and also having some control over the composition of their household, are the required to have a roommate? If they are, can they choose the roommate? Can they choose to have a roommate or not? Lots of time people may choose to have a roommate because it makes the unit more affordable. What are we all interested in when finding housing? Do I need my housing to be on a bus line?, maybe so, do I need my housing to allow me to have a pet? Maybe so. Again, the fundamental idea, the fundamental approach is that the needs that people with mental illnesses or co-occurring disorders have around housing are no different than anyone else's, and the interest around housing are fundamentally no different than anyone else's.

Moving to services, the primary thing to know about services is that we are not placing people in housing, we are not placing people in a service program, and it is not a cookie cutter approach. The goal, as Fran said at the beginning of the call, we know that PSH done right really ends personal homelessness for the people who are involved, is a tool in ending homelessness in communities, and it is a path to recovery, to genuine recovery for people with behavioral health disorders, and so services are the magic.

We have some recommendations in the toolkit about how to provide services. First of all if we are serious about limiting access requirements to housing, than we have to have the capacity to provide a full range of supports. Early intensive supports wrap around ongoing, not time limited. The toolkit recommends a 1:12 staff to tenant ration and a successful approach that I believe Joseph will talk about is a team approach and so you might pull together a team that includes peer specialist, housing specialist, case management, perhaps someone like a psychiatric nurse, but it's the team approach that seems to have some magic. Remembering always that individuals are going to have choice in the supports that they receive, there are things to consider, what are your hours of operation, a 9-5 approach is not going to work. You have to think about how people are going to, what are they going to do in a crisis, what are they going to do in an emergency. Basically, this is where the magic is, and when we talk in the subsequent about this dimension, it's a dimension in the fidelity scale, we will talk at some depth about the kinds of services and supports that seem to be most successful.

The last core element that I wanted to explore briefly is that we believe, the developers of the kit believe, and the research supports, that the separation of housing and services is essential, housing is housing and services are services. Case managers should not collect rent.

To sum up I want to remind you that SAMHSA's toolkits in general, including this toolkit offer all of us the resources that we need to implement and assess clinical practices that actually work. And the emphasis on implementing EBP's, which is what PSH is stems from a consensus that there is a gap between what we know about effective treatments and the service systems we currently have. There is no blame attached to that, that's just the reality and anybody who has worked in the publicly funded system knows that that's true. EBP's are linked to predictable beneficial outcomes for real people and if those outcomes are what you in your system, then implementation of an EBP through fidelity is a necessary part of what you need to do.

In evaluation your program, there is a fidelity scale, and I recommend you take a look at that. The dimensions of PSH fidelity are the things that are listed here, and as I said

before we will do two more webinars, one in July and one in August where we really will take a detailed look at how programs make these dimensions real.

And that concludes my portion of the presentation, so Justine back to you.

Justine Hanson:

Thank you Ann, and thank you for that very useful information. Our next presenter is Joseph Tardella, Executive Director of Southwest Counseling Solutions, SWCS; a community based mental health and human services organization located in Detroit, Michigan. SWCS provides mental health, substance abuse, supportive housing, supportive employment, juvenile justice, youth development, family literacy and early childhood education services to individuals and families. SWCS currently supports over 450 individuals and families in its PSH programs. Mr. Tardella currently serves as the president of the Homeless Action Network of Detroit.

Joseph, thank you very much for being with us today.

Joseph Tardella:

Thank you Justine, thanks for the nice introduction.

Good afternoon, my task for the next 30 minutes or so, 25 minutes or so is to examine the core elements of PSH, some of the things that Ann spoke too, and speak to their practical application in live settings, specifically Detroit, Michigan. I'll be speaking to the questions that need to be considered when an organization decides to develop a housing program, and I will be examining issues that have the most practical impact on this decision. I will be speaking primarily from an organizational, form a program development point of view; I will be speaking specifically to the efforts of Southwest Solutions in Detroit. Southwest Solutions is a family of non-profit corporations whose corporate structure includes both a non-profit counseling corporation and a non-profit housing corporation.

Our supportive housing program serves folks that are homeless, many of whom have histories of chronic homelessness, and most of whom have a serious mental illness. We

are currently providing 450 housing opportunities. We are using both a single site and scattered site approach; we employ a number of different rental assistance programs. We are also serving as the lead organization in distribution of around $3 million in tenant based rental assistance that was made available by the state of Michigan; and also serving as the lead on the distribution of about 1,000 Section 8 vouchers that were set aside for folks that are homeless.

The learning objectives for this portion are to identify the issues that need to be addressed, the questions that need to be answered, the stakeholders that need to be engaged during the planning and development of a PSH program, and then how to best align your program with the core elements of the toolkit.

Before I begin, I would like to kind of put the Detroit experience in perspective. Last year the HIS recorded an unduplicated account of about 20,000 individuals and families that were requesting services from one of the many organizations that serve the homeless; shelters, transitional housing programs, soup kitchens, drop-in centers, warming centers, support service providers, that represented about a 5% increase over the previous year. Of those 20,000, about 12,600 were single, over 7,400 were families. Both had shown an increase compared previous years, and the number of individuals reporting being homeless for the first time also increased about 40%.

On the resource side, Detroit receives over 23 million dollars in HUD Homeless McKinney-Vento funding. That supports about 1600 emergency shelter heads, about 2600 transitional heads, and about 4700 PSH projects. The number of permanent housing projects has increased about 30% over the last couple years. In part it was the result of the state housing authority and their emphasis on homelessness; they set aside over a 1000 section 8 vouchers, they invested 3 million dollars in TBRA dollars, so their involvement was extremely important.

So that the system which we are operation. Many organizations in Detroit have recognized the importance of PSH as a solution to homelessness. We are continuing our efforts, we have several projects in the pipeline and this is despite a rather challenging economic and real estate environment.

So what are the questions that organizations need to consider as they develop their strategy? I will base this discussion on lessons learned by Southwest and other Detroit based organizations that have developed PSH. These are the steps, these are the questions that organizations have taken into consideration during their development program. It is not meant to be a one size fits all approach; different communities present different opportunities, different challenges. Nor are these considerations meant to be necessary sequential, many of the discussion will take place concurrently, but in my experience these questions and others will need to be addressed.

So let's begin with identifying the need, who you are intending to serve. Often times especially with support service organizations that are considering housing programs, these are members of the population that you are already serving, and your interest in PSH evolves out of the service gaps that have been identified by the folks you serve. In certain situations it is housing developers looking to provide supportive housing, but regardless of whether you are a service provider or a housing developer you'll need to determine the characteristics of the folks you intend to serve; their levels of need, their strengths, their abilities, their income, their current resources and their current housing options. Most importantly, you need to determine what their housing preferences might be; studio apartments, one/two bedroom apartments, single family homes, congregate living, single person living; the answers to these questions will inform your decisions regarding housing type, housing model, location, layout design, but most importantly these answers will also begin to inform your decision regarding the development and the design of your supportive services model, and I'll speak more to that later in the presentation.

Articulating your housing solution; let's begin with your logic model. You've identified your resources, you've identified activities, you have a theory of change, you've identified short, medium and long-term objectives, and finally you've looked at the impact and the outcomes of your program. You've asked yourself how will PSH improve the lives of the folks I intend to serve, how will it improve the community, what have we learned from the experience of others, who are my partners, are there others in the community that can provide this service, and are they better positioned than I?

You also need to begin to assess the readiness of your organization. Is your articulated housing solution, is your logic model aligned with the mission vision of values for your organization, and this is a crucial question. You also need to determine whether your organization has the capacity and skills to succeed; real estate development is not the same as providing support services. So if you are a support services agency, what new competencies and skills will be required? What have you done to prepare your board, your executive leadership, your financial staff and your clinical staff for this new book of business, this new business line? Are you organizational values consistent and aligned with the principles of Housing First; choice integration and dependence? Maybe it is a good time to begin to ask yourself whether you are Housing First ready, and I think we can talk more about this during the question and answer session. But in your organization, is your organization willing to accept that housing is not dependent on participation of services, that services are voluntary.

Lastly, do you have both the front lines, clinical and backroom capacities to succeed? If you are a service provider, recognize that supportive housing is not business as usual.

Now let's talk about community readiness. Have you identified the stakeholders in your community? Those who support an agreement will be important as you move forward; the folks who fund you, the policy makers, your neighbors, the community leaders. Is there an alignment between your vision and their vision, between your interest and the interest of the community? Is your solution a solution that all can agree to, at least live with. Are you prepared to communicate with those who may not support your solution? Are you prepared to confront NIMBYism, community opposition? If so what is your message; it is convincing, it is compelling, does it paint a clear and accurate picture of what you are trying to achieve? Most importantly, how will this benefit the community?

Build it, buy it, partner for it.

At some point early in the program development, you are going to have to answer this question: what is it you're going to build, what is it you're going to buy, and what is it you're going to partner for. If you decide to build, to become a housing developer, especially if you're a support services provider, be sure that you have the real estate

developer expertise. It's a specific set of skills; it has implications for staffing as well as governance. Securing the financing, closing the deal, acquiring the proper zoning permits, managing the constructions, developing the property management protocol, these are not things that most mental health professionals have. Again, and I'll repeat this often, the development of supportive housing is not business as usual.

Several of the key decisions that you'll need to make along the way, who's the adult in charge, who's the owner, who will act as developer, who are the investment partners, who will manage the project to completion, who will serve as the property manager, what is the relationship between property management and support services, and how clearly have you separated these functions and defined these roles? Have you developed a blended management strategy; how will you implement blended management; how will this separation result in integration and coordination across your program.

In selecting partners, number one rule, choose your partner carefully. Be sure that all parties understand the commitment and are in agreement with you on core principles and core values. Alignment of values is crucial; time spent in the discussion on the front end of the project will saved you a lot of time on the other end. Determine as much as possible on the front end, who is responsible for what? Put these agreements in writing, don't assume anything; get everything on the table, discuss all the possible areas of conflict and have proactive procedures in place to address them.

Assessing the funding climate; how will you financially support your project? So, you have decided who it is you are going to serve, you've developed your logic model, you've articulated your plan, you've done your due diligence with all your key stakeholders, and you are on your way. Now how are you going to pay for this? What is your business model? Is it based on best practices? If you are a support service provider what are the sources of funding for housing development. If you are a housing developer, how will you fund support services? Have you developed a working budget, a pro forma for the project, and has it been vetted by those with appropriate background and experience? Have you begun to identify the organizations that have access to funding that's necessary to support and finance your project? If you are looking at HUD funding,

have you become a player in your local continuum of care; are you familiar with your communities plan to end homelessness and increase access to affordable housing. Have you identified funding available through the McKinney-Vento program and the HEARTH Act? Have you begun your discussion with state housing authorities; have you identified and become familiar with local policies that govern the development of affordable housing. Have you reviewed their consolidated plan? Have you begun to engage local public housing agencies? Have you determined their policies and practices on special populations and perhaps their past approaches to end homelessness, especially with those folks with psychiatric disabilities? You have to remember that PHAs are required to address the housing needs of individuals and families that are in most need of assistance. You have to ensure that the needs of the populations you are serving have a place at that table.

Have you prepared your board for the financial complexities in funding a project, and the required monitoring and the financial **[not audible]** that will result. Most projects will carry debt, is your organization and your board ready to assume a long-term debt obligation?

Let's talk about selecting a housing model. Ann spoke earlier about the models of PSH efforts that are in place so there is no need to review that, but I'll speak later to some of the consideration of each model. At Southwest we developed all three; we have a single site, single use facility that provides permanent housing to 150 veterans using a combination of both section 8 and VASH vouchers. Most of our housing takes place in single site, mixed use buildings and we have about 200 scattered site units with about 85-100 landlords.

Single site considerations.

The project based single site model, whether mixed-use or single-use allows for some economies of scale and ease of service delivery. Several supported tenants in one place allows for the opportunity for easily accessible on-site services. Single site models can provide opportunities to develop a sense community among the residents of a similar background. It can facilitate the establishment of a blended management model. It allows

individuals to learn from the success of others with similar disabilities and backgrounds. It can provide a sense of camaraderie and may limit isolation. Mixed-use facilities also allows for more naturally occurring integration into the community. Increasingly mixed-use, single-site projects are being developed; these models maybe more acceptable to the community. Many projects open the building to the community residents and for community activities. At Southwest, upon recent acceptance we've employ mixed-use models on all of our developments. Typically we identify about 33% of the units as supported units, the remaining units available to low to moderate-income members of the community.

In the scattered-site model, the model certainly speaks most clearly to participant choice. Participants have a wide choice of geographic options and they can usually locate a home near those things that are important to them: families, friends, familiar places; and they can more easily blend into the social fabric of the community; the stigma of have a mental illness or being formally homeless may not be as apparent in a scattered sight model.

The model does however present some unique challenges to service delivery. At Southwest we manage about 200 sponsor based care subsidies, using a scattered site model. The economies that are available in the single-site model are not available using a scattered-site model. Support services staff need to be mobile; they need to travel to meet with program participants. Typically one or two residents in a building are receiving support services. Scatter-sites do not typically offer space for individual meetings with participants so meetings often take place in tenant's apartments or nearby community locations. Most importantly you must partner with multiple landlords and property managers across the greater Detroit area. Much time is spent on landlord selection, landlord recruitment, and landlord retention.

Let's talk for a couple minutes about the uses of rental assistance. As Ann indicated, if you are intending to serve a disabled population, a population of folks on SSI/SSDI, rental assistance is a necessary part of a mix. Remember that core element of affordability, the HUD definition of rent burden is spending 30-50% of your rent on

housing costs, over 50% is considered severely rent burdened. Monthly SSI income, if I am not mistaken, is currently about $674 a month, plus in some states a small paid supplement. Although housing costs vary greatly by region, monthly housing costs in most jurisdictions exceed $674 a month. In Detroit, the FMR or the Fair Market Rate for a one-bedroom apartment is $676, approximately equal to SSI income, so rental assistance of some sort will be needed. Typical sources of rental assistance; shelter plus care for folks who are homeless with a disabling condition; housing choice vouchers, Section 8 for folks who meet low income guidelines; TBRA, Tenant Based Rental Assistance funding which is available through HUD home dollars, it is often time used for bridge funding; and then VASH vouchers that are set aside for specific populations.

The use of bridge funding has been a pretty interesting project in Detroit. I indicated early that the state housing authority released over 3 million dollars in TBRA funding, and then over the next three years they set aside 1,000 section 8 vouchers and gave priority to those folks who had temporary vouchers, allowing for the swap out a TBRA voucher for a Section 8 voucher, resulting in over a 1,000 successful placements.

One last consideration about rental assistance and this is an important one. If you are considering rental assistance, don't forget about the backroom functions and compliance obligations and ensure that you have the capacity to manage rental assistance. You will be establishing individualized rental payment plans with every tenant, you will be paying landlords, you will be ensuring that your tenants pay their required thirty percent, you will be monitoring utilities to ensure that folks remain housed, you will be doing initial and annual inspections, you will be doing initial and annual income verifications, you will be managing money, you will be assisting in budgeting, in some cases you will be serving as the addressee, so ensure that you have the policies in place to guide these transactions between your staff and tenants. Also assume that if your organization qualifies for a Federal A133 audit, that your rental assistance program will be tested for its compliance with federal guidelines. At Southwest it took many, many lessons learned. We separate our housing charts from our support services charts, and we separate the responsibilities for those functions. We have a four-person compliance team, including a full time H2S inspector and two bookkeepers that manage the rental assistance portfolio.

We cut over 400 checks a month and we serve as the payee or addressee for about 35-40 of our supported tenants. We provide budgeting assistance, payee services and we perform approximately 450 H2S inspections every year.

So the takeaway is this, rental assistance is a great experience, it's a wonderful resource, it clearly addresses the affordability issue, it allows folks who would not be able to afford housing the opportunity to live in a place of their own, but take the compliance piece seriously. Ensure you have the policy, procedures and staff in place to manage it.

Developing your service delivery model.

This is probably the most difficult section to speak to. As Ann indicated there is a booklet in the toolkit devoted specifically to support services. We could probably devote an entire series of webinars to this topic and barely begin to scratch the surface; having said that the development of your service delivery design is central to your PSH project. PSH organizations that evolve from behavioral health organizations often times deliver these services in house through staff assigned specifically to the program or through referrals that are internal to the organization. In other organizations that are principally housing development organizations often times look for a support service partner. Regardless of the situation, whether the support services are delivered directly by your staff or through a contract or series of contracts with other community providers, recognize that individual tenant needs vary and are ever changing and that the service required by any one project will vary over time. The needs of a new, formally homeless tenant with complex needs are much different than the needs of an individual that is well into their recovery process and have several years of successful tenancy; so adjust case loads and adjust your service delivery system based on the needs of the folks you are serving. Remember that the ultimate goal of services is to ensure that individuals are offered a set of tailored services, flexible services, services that ensure successful tenancy and housing stability, and also provide opportunities for growth, recovery and increased self-sufficiency.

You need to ensure that your service design support the central themes of PSH. Your design should be responsible to the needs of the population you are serving; they should

be based on a best practice model; they should be flexible and tailored to your population; they should honor participant choice and participant involvement; they should ensure ease of access, promote community integration and promote recovery.

You know we spoke earlier to the advantage of the single-site model and to the advantages of the scattered-site model, but recognize a person who may be successful, a model that may be successful, and a single site approach may not be the best approach in the scattered site model. On site staff are often stationary and site based; staff that work in a scattered site model are often out there on their own, they are home based, they are community based; they are delivering support systems in the absence of immediate access to a services team. So select your staff and place them in position to clearly play to their strengths.

I'd also like to take a few minutes to speak to the use of peer support specials. For Southwest and many of our partners in Detroit, the use of peer specialists has been invaluable. Their ability to engage reluctant tenants, to instill hope, to model recovery; you know there is something about having "been there and done that" that seems to speak volumes to the individuals whose past experiences to the mainstream service system has been frustrating and less than empowering. So at Southwest we use peers throughout the organization, but frankly the best fit has been with our PSH program and working with homeless individuals.

Central to your service delivery model, and I'll speak briefly to this, is the role of your case manager or resource coordinator or service coordinator, regardless of what you call them I am talking about the person of the team that is most responsible with the day to day interactions with the folks you house. These people typically where many hats, they are housing specialists, resource coordinators, mental health chemical dependency specialists, they are services brokers, they are counselors, they are entitlement experts, but also recognize that the folks you serve often time request services that may be beyond the expertise of one person alone. So assemble a team, look for staff or partners that offer specialized services: primary care, supported employment, specialized mental health, integrated dual diagnosis treatment and make them apart of your team.

In terms of recruitment of staff, ideally we look for someone who's familiar with model, who knows the community, who know housing resources, knows the community resources, but frankly that can be taught. We are more interested in the things that are more difficult to teach: empathy, respect, flexibility, determination; someone who is comfortable in the community and comfortable with visiting folks in their own homes. Most importantly, look for individuals whose personal values are aligned with the values of the program. In terms of still training, the list is endless: engagement skills, motivational interviewing, depending on the population you serve an understanding of homelessness or mental illness or chemical dependency, dual disorders, crisis intervention techniques, conflict resolution techniques, cognitive behavioral strategies, cultural competence, entire housing laws, the list is endless.

Remember the direct service staff of your organization are the face of your organization, select them wisely, provide them with training and support and don't forget to celebrate their success.

The last thing I'll speak to is evaluating your program, and Ann spoke to this earlier. But begin with your logic model; it is a great starting point for your evaluation. What were the outcomes you expected to achieve and how did you intend to measure them. Let's go back to your intended population and in what way did your housing solution propose to improve their lives, and how can you quantify and measure these gains?

What are the industry standards regarding the measurements related to recovery, to personal improvement to self-sufficiency? If you are serving folks that have a mental illness, how can you measure improve functioning, improved access to care, reductions in high end services? If you are serving folks that are homeless how can you look at measures of self-sufficiency, at housing tenure? How will you measure housing retention: at 6 months, at 12 months? What is your threshold for success?

You should also determine what you are already required to collect on your various funding entities. Try not to duplicate using additional measures that are basically looking at the same outcome. Look for measures that are norm, valid and provide training to ensure greater reliability. Ann spoke earlier to the SAMHSA fidelity measures; determine

how you incorporate these measurements into your program evaluation design, they will truly inform and guide your efforts.

On a more practical level, determine who is responsible for collecting the data; where does the data live? Set aside resources to support this and most importantly determine how the data will be used to improve program performance, to educate the community, to influence policy and decision-making regarding funding.

Lastly, recognize a program evaluation there is a size and application and robustness. But whatever the size and scope of your evaluation especially in an era of ever shrinking resources, performance based contracting, value base purchasing, outcomes reign supreme so collect your data, use the data wisely and make sure it tells the story.

That concludes my presentation.